involved in patient care is vital, especially when patients are being managed out of locality by different teams.

The project aimed at assessing if discharge summaries for General Adult inpatients across all four localities of the Trust was made available and in a timely fashion on patient electronic records as well as to primary care using national guidelines as the standard. Using the same guidelines, it also evaluated the quality of the summaries based on the information contained.

Methods. Data was retrospectively collected in October 2023 for general adult inpatient discharges for the month of January 2023 across all four localities of Black Country Healthcare NHS Foundation Trust. Records for 148 out of the 152 discharges were assessed. Data was collected from electronic patient records Rio and evaluated on Microsoft Excel. The evaluation checked whether discharge summaries were available, duration between discharge and its availability on electronic records as well as contents of summary. Professional Record Standards Body and the RCPsych guidelines were used as standards.

Results. 28 of the 148 (18.9%) patients did not have a completed discharge summary. Of these, 14 (9.4%) were out of locality patients. The average duration from discharge to summary being made available was 12.7 days. Most of the summaries contained all relevant information as per guidelines.

Conclusion. The findings were presented to the Trust's QI committee. It was concluded that while majority patients had a summary made available, there is a need for additional strategies to ensure summaries are available soon after discharge to ensure safe post-discharge care.

It was identified that the bed management team should notify parent teams of admissions and discharges promptly.

The medical secretary is to monitor the admissions register and ensure the junior doctors in the team complete discharge summaries in a timely manner.

Business intelligence team to use clinical coding to identify any missing discharge summaries and provide medical teams with a monthly report in case any are missed by the secretaries.

Once above recommendations are implemented, a re-audit would help to analyse the improvements in practice. The results would also help guide the Trust in developing a policy to harmonise processes across the Trust and thereby ensure safe patient care post-discharge.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Audit of Documentation of Lifestyle Medicine Factors in the Leicestershire Early Intervention Psychosis Team Clinic Letters

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Aims. Lifestyle medicine promotes the use of therapeutic lifestyle interventions to modify disturbed lifestyle factors which are thought to underlie chronic illnesses, including mental health conditions. It is important to identify and manage any disruptions in factors that lifestyle medicine has identified as being contributory towards sustaining good health. Aims were to identify the extent to which the early intervention in psychosis (EIP) medical team in Leicestershire are enquiring about the pillars of lifestyle medicine.

Methods. There are 6 pillars of lifestyle medicine, namely exercise, sleep, diet, refraining from toxins, positive social interactions and quality personal time. Motivation has been added as the 7th pillar for this audit. Gold standard would be to adequately explore all pillars at each medical review. Retrospective analysis was done of electronic patient records (SystmOne) for all patients on the EIP team case load, available on 19th May 2023. Information was gathered from the most recent medical review, using a predefined audit extraction tool. Information on each pillar was assessed based on whether it was fully explored, mentioned with some detail, mentioned with no further detail, or not mentioned at all. Data collection was carried out by three members of the team (TC, SA and DG).

Results. 495 patients were identified and 459 had information from a latest medical review found on SystmOne. For all domains, "not mentioned" was the leader, ranging from 48.6–70.8%). For all domains, except for refraining from toxins, the second most common finding was "mentioned with no further details".

Conclusion. Our results suggest EIP medical staff are either not discussing many of the seven pillars of lifestyle medicine with patients, or not documenting them in sufficient detail. Limitations of the study include that it was the most recent medical review being audited and there could have been more detail documentation in previous reviews. Distribution of the findings and recommendations from the audit were shared with the team and an educational poster detailing lifestyle factors was created. The online system is being adapted to include an option to input lifestyle factors. Re-audit should be done in 12 months.

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Autistic Spectrum Disorder in Young People Presenting to a Paediatric Specialist Fatigue Service

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Aims. To investigate whether young people referred to a paediatric specialist fatigue service present with higher levels of autistic traits or have higher prevalence of Autistic Spectrum Disorders (ASD), than those found in the general population.

Methods. 143 initial assessment reports of young people presenting to a paediatric specialist fatigue service were audited over a 5-month period to identify cases where a previous diagnosis of ASD has been documented, or the assessing clinician has recommended referral for an ASD assessment, or autistic traits have been documented in neurodevelopmental screening. Comparative data on age, gender, age of symptom onset, duration of symptoms, reported symptoms, comorbidity, family history, and sleep difficulties was then explored to help us identify/understand the profile of the young people who present to our service. Routine mental health screening questionnaire data from the Revised Children's Anxiety and Depression Scale (RCADS) was analysed in addition to clinical reports regarding mental health comorbidities.

Results. Of the 143 young people presenting to the specialist fatigue service over the 5-month period, 16 had a diagnosis of

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ASD, and 41 were suspected as having ASD. In total, 39% of service users had, or were suspected of having, ASD. The prevalence was higher in female service users than males with a total of 48% of female service users having, or being suspecting of having ASD, compared with 22% of males. Comparative data demonstrated that autistic/suspected autistic young people presenting to the service were more likely than their neurotypical counterparts to be: over 13 years old, have a longer symptom duration before presentation, have an Educational Health Care Plan, report friendship difficulties, have a family history of neurodiversity, report sensory difficulties, and have sleep difficulties. RCADS scores found that the ASD group were more likely than the neurotypical group to have clinical levels of anxiety (58.3% vs 15.3%) and depression (80.6% vs 58.3%).

Conclusion. Our audit suggests that there is a higher prevalence of young people with ASD/ASD traits presenting to a paediatric fatigue service than found in the general population. Reasons for this may relate to undiagnosed ASD presenting as severe fatigue due to the energy draining nature of camouflaging, as well as sensory overload, known as autistic burnout. Do we need to develop a specialist treatment pathway which is better adapted to these young people's needs? We are planning a follow up study and focus groups to explore this complexity further.

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Psychiatric Emergency Bleep Documentation Enhancement Audit

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Aims. West Lothian Psychiatry operates in a district general hospital, fostering a close working relationship between medical and psychiatric practitioners including the Psychiatric 2222 call (akin to medical emergency/cardiac arrest response). No other team like this has been identified in Scotland. Whilst there is a range of scenarios where this is used, there is no 'gold standard' for defining a psychiatric emergency or how to document these. Preliminary data gathered between August and November 2022 revealed concerns regarding call appropriateness, medical staff proficiency in de-escalation and restraint on medical wards, inadequate handovers, and poor documentation. This prompted a collaborative quality improvement project, undertaken by psychiatric and medical team leaders. Part of this initiative was an audit to improve the documentation of psychiatric emergencies to achieve a 90% compliance rate using a new checklist.

Methods. Cycle 1 of the audit (December 2022 to April 2023) identified patients through the 2222 calls to switchboard (n = 54). TrakCare notes were reviewed to assess call rationale and outcomes, focusing on documentation by the attending psychiatric team. A documentation checklist within the electronic records system was designed and introduced in July 2023, for completion by the junior doctor. Cycle 2 (November 2023 to January 2024, n = 47) aimed to assess improvements by comparing results with the previous cycle.

Results. There was a significant improvement in documentation rates with the checklist (44% to 90%). Indirect enhancements were observed in ward nursing documentation (65% to 83%) and medical ward doctor documentation (39% to 57%). Appropriateness of emergency calls increased from 65% to 74%, with attending doctors' participation in emergencies longer than 10 minutes rising to 68% from 47%. The initial audit revealed a lack of awareness among senior medical staff regarding overnight psychiatric emergency calls, especially in cases of repeated calls for the same individual. The improved documentation played a pivotal role in addressing this issue, facilitating effective information sharing and changes in patient management plans, reducing further emergency calls.

Conclusion. The documentation checklist significantly improved junior doctor documentation, positively impacting patient care and communication among staff. This successful intervention serves as a promising model that can be replicated in other documentation domains. Moreover, this project has set the stage for broader initiatives within a larger Quality Improvement framework. The ongoing efforts are directed towards establishing a shared model for the psychiatric emergency bleep, optimising staffing resources for restraint procedures and improving staff de-escalation skills.

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An Audit of the Prescribing and Monitoring of Antipsychotic Medication in an Older Adult Inpatient Psychiatric Ward Using NICE Guidance [CG178] Psychosis and Schizophrenia in Adults: Prevention and Management

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Aims. The National Institute for Health and Care Excellence (NICE) offers guidance for prescribing and monitoring of antipsychotic medications. In this audit we sought to investigate if our unit was compliant with this guidance.

Methods. The audit was carried out on a 28 bedded older adult inpatient psychiatric unit. The notes of all patients admitted to this ward on 27/11/2023 were reviewed. Any patient on an antipsychotic was included in the audit. Four standards reflecting the prescribing and monitoring of antipsychotics were identified. These were:

1.3.5.1 The choice of antipsychotic medication should be made by the service user and healthcare professional together, taking into account the views of the carer if the service user agrees.
1.3.6.1 Before starting antipsychotic medication, undertake and record the baseline investigations.
1.3.6.2 Before starting antipsychotic medication, offer the person with psychosis or schizophrenia an electrocardiogram (ECG).
1.3.6.3 Treatment with antipsychotic medication should be considered an explicit individual therapeutic trial.
1.3.6.4 Monitor and record the following (response to treatment – side effects – adherence – physical health) regularly and systematically throughout treatment.

These five areas of guidance were broken down into 22 domains which are outlined in results below.

Results. Of 28 patients admitted to the ward, 22 were on antipsychotic medication.